

Student Accident Claims Overview

- NEW Claim Forms
- Supplemental coverage under your GL
- Secondary to any other insurance
- Claims handled by experienced professionals
- **Claims must be received within 90 days**

Student Accident Claims Reporting Process

Action Items when Student is Injured at School*

- Complete internal incident report
- Complete school section of claim form
- Provide claim form to parent for signature
- Forward signed form within 90 days to VACORP
- VACORP will contact parent for information, bills

*School-sponsored event/activity. Athletics may be added

Claim Form Part 1: Incident Information

This form must be returned **to the School within 90 days from the date of incident.**

VACORP will send parents information on submitting bills and EOBs for consideration on applicable claims (*School will not accept bills or EOB documentation*).



VACORP
(888) 822-6772

STUDENT ACCIDENT CLAIM FORM

Student Accident Coverage is SECONDARY to any other insurance, including Medicaid, FAMIS, or private health insurance.

PART 1: INCIDENT INFORMATION (TO BE COMPLETED BY THE SCHOOL)

School Division: _____

School Name: _____

School Address: _____

Student's Name: _____

Male Female Date of Injury: _____ Date of Birth: _____

Grade Level: _____

Body Part: _____

Description of Accident (Include an additional page if needed):

If Athletics, please indicate the sport:

At the time of injury, was the student involved in a School Division sponsored activity? Yes No

Under whose supervision? _____ Phone #: _____

Signature of Preparer: _____ Title: _____

Printed Name: _____ Date: _____ Phone #: _____

Claim Form Part 2: Parent Information

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH *STUDENT* AND *PARENT* INFORMATION)

Student Information:

Student Address: _____

Parent Information:

Father's Name: _____ Phone #: _____

Father's Employer: _____

Employer's Address: _____

Mother's Name: _____ Phone #: _____

Mother's Employer: _____

Employer's Address: _____

Please list **ALL** insurance policies: Check if No Insurance

Name of Insurer: _____

Address: _____ Policy #: _____

Phone #: _____ Group Individual

Treatment Information:

Physician/ Facility Name: _____

Address of Physician/ Facility: _____

Phone #: _____ Date Seen By Physician/ Facility: _____

Claim Form Page 2: Claim Instructions

Instructions:

In case of an accident, notify the school immediately.

1. Complete this claim form and return it to the school within 90 days from the date of injury.
2. Please include information on any available health care insurance, including Medicaid.
3. In order to process this claim for payment, VACORP will need itemized bills and all Explanations of Benefits (EOB) showing what your insurance has paid. Statements without itemized information will not be accepted.
4. When you receive your EOB, send it to VACORP, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the contract.
5. Benefits are paid directly to the providers of service unless VACORP receives paid receipts.

Student Accident coverage is only available to cover students for accidental injury occurring while the contract is in force.

Benefits are provided on a **SECONDARY** excess basis for covered expenses **incurred and reported** within one year after the date of the accident.

Benefits are payable up to the applicable maximum for the covered expenses that are in excess of other valid and collectible insurance including: Medicaid, Medicare, FAMIS and private health insurance.

This claim form must be submitted to VACORP by the school division prior to any bills being reviewed or processed.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits; otherwise, VACORP's benefits may be reduced, where applicable, as stated in the contract provisions.

Claim Form Page 2: Parent Authorization

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employee having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to VACO Group Self-Insurance Risk Pool (VACORP) or its legal representative, any and all such information.

I UNDERSTAND the information obtained will be used by VACORP to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by VACORP to any person or organization except as necessary in connection with the processing of this application, claim or as may be otherwise lawfully required or as I may further authorize. I further understand that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to VACORP.

I CERTIFY that the information given by me in support of this claim is true and correct.

Any payment will be made to the service provider (hospital, physician, and others) unless a paid receipt or statement accompanies the bill when the claim is submitted to VACORP.

AFFIDAVIT: I verify that the statement in Part 2 about other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via US Mail may be fraudulent and violate federal and state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim, I will reimburse VACORP to the extent VACORP made a payment for which it was not obligated under the contract.

Parent or Authorized Representative's Signature: _____ **Date:** _____

If Authorized Representative, Relationship to Student or Legal Designation: _____

Reporting Claims Online

The screenshot shows the VACORP website with a browser window. The address bar shows <http://www.vacorp.org/>. The VACORP logo is in the top left. A central blue banner reads: "VACORP IS HOSTING A FREE WEBINAR: STUDENT ACCIDENT CLAIMS REPORTING OCTOBER 18, 2016 AT 10:00 A.M. For all Finance Directors, Administrators, School Secretaries, School Nurses, Coaches, and Athletic Directors. CLICK HERE TO REGISTER". A red arrow points from the title to a "LOGIN" button in the top right. Below the banner is a navigation menu with "SERVICES" and "CONTACT". The main content area features the slogan "The STRENGTH you need. The PARTNERSHIP you expect." and five service categories: Local Governments, School Divisions, Corrections, Authorities, and CSBs, each with a brief description and a "More" button.

VACORP

**VACORP IS HOSTING A FREE WEBINAR:
STUDENT ACCIDENT CLAIMS REPORTING
OCTOBER 18, 2016 AT 10:00 A.M.**
For all Finance Directors, Administrators,
School Secretaries, School Nurses, Coaches,
and Athletic Directors
[CLICK HERE TO REGISTER](#)

LOGIN

SERVICES CONTACT

**The STRENGTH you need.
The PARTNERSHIP you expect.**

Local Governments
We provide coverage to more counties, county school systems and county-related agencies than any other provider.
[More](#)

School Divisions
School divisions all across the commonwealth partner with us for a customized risk management program tailored to their needs.
[More](#)

Corrections
The myriad threats and liabilities that corrections facilities face every day can be daunting, but we give peace of mind to jails from Bristol to VA Beach.
[More](#)

Authorities
Authorities use us for property and liability insurance, along with other specialized other coverages to protect them from loss and damage.
[More](#)

CSBs
CSBs have unique and various exposures that need to be addressed and we are in a strong position to make sure they are completely covered.
[More](#)

Reporting Claims Online

The screenshot shows a web browser window with the URL https://member.vacorp.org/VACoRP/VACoRP_Home.aspx. The browser's address bar and menu bar are visible. The website header features the VACORP logo and the text "Risk Management | Coverage | Claims Resolution" over a background image of a green field and a tree. Below the header is a navigation menu with "HOME" and "ABOUT US" (with a dropdown arrow). A blue box in the center contains the text "PLEASE LOG IN BELOW TO ACCESS VACORP MEMBER FEATURES" and a login form with fields for "Login:" and "Password:", and "Login" and "Reset" buttons. At the bottom of the page, there is a footer with the text "If you need login information, please contact Member Services at 844-986-2705".

Please Note: system security feature will – without warning – automatically log out screens that remain idle over 15 minutes

HOME ABOUT US

PLEASE LOG IN BELOW TO ACCESS VACORP MEMBER FEATURES

Login:

Password:

Login Reset

If you need login information, please contact Member Services at 844-986-2705

Reporting Claims Online

VACORP
Risk Management | Coverage | Claims Resolution

HOME | **REPORT A CLAIM** | RESOURCES | SITE TOOLS | ABOUT US

Welcome

You have 25 open claims. [View Now](#)

Your last visit was on 10/14/2016 11:14:51 AM [Logout](#)

Current FY Claim Status

Status	Count
Closed	3
Open	12

Financial Data for past 5 Years

Year	Reserve Amount	Incurred Amount	Collection Amount	Paid Amount
Year 1	~10,000	~10,000	~10,000	~10,000
Year 2	~15,000	~15,000	~15,000	~15,000
Year 3	~25,000	~25,000	~25,000	~25,000
Year 4	~15,000	~15,000	~15,000	~15,000
Year 5	~10,000	~10,000	~10,000	~10,000

Reporting Claims Online




- Go to www.VACORP.org and login. Select “Report a Claim” link located in the menu bar at top of the page. Clicking this link will open a **new window** and present four boxes labeled as follows:
 - Event Information
 - Event Details
 - Person Involved
 - Finished
- To report a claim, complete as much information as possible. Since the claim details will be included on the Claim Form, you must complete fields marked with an asterisk (*), before the claim may be submitted.

Claim Data Entry Box 1: Event Information

* Indicates a required field.

Event Information

Event Information

Claim Type	GL/Student Accident ▼
* Event Date-Time	<input type="text"/>  
Event Date-Time Reported	10/14/2016 4:43 PM  
* Department	(000) Student Accident ▼
* Contact Name	<input type="text"/>
* Contact Phone Number	<input type="text"/>

Event Details

Person Involved

Finished

Claim Data Entry Box 1: Event Information

- Claim Type: Default is Student Accident
- Event Date – Time: click on calendar/clock
- Department: Student Accident
- Enter Contact Name and Phone Number of the school division employee that can best answer questions about the claim

Claim Data Entry Box 2: Event Details

Fields with * must be completed, but provide as much information as available.

- Cause Code: select best match
- Event Description: enter brief description or indicate “see attached claim form”

Claim Data Entry Box 2: Event Details

*** Indicates a required field.**

Event Information

Event Details

Event Details

Event Address 1

Event Address 2

City

State

Zip Code

* Cause Code

* Event Description

General Liability

Injury Description (if any)

Claim Data Entry Box 3: Persons Involved

- Enter Student Information - **REQUIRED**
 - First and Last Name
 - Address
 - Phone Number
- Must click “Add to Claim” for info to be saved
- Other info will be on claim form submitted

Claim Data Entry Box 3: Persons Involved

Person Involved

Select a person type to add.
Search for them in the system.
Update their information as needed.
Make sure to "Add" them to the claim using the button provided.

Find Person

PI Information

Person Involved Type

Last Name First Name Middle Name

SSN DOB

Title Gender

Address 1

Address 2

City State Zip Code

Phone Number

Email

Person(s) Involved

John Doe

Click Add to Claim



Name must appear in box



Claim Data Entry Box 4: Finished

- Enter email address for person(s) to receive confirmation email from VACORP
- Click Submit Claim for **unique claim number**
- Select Upload Attachment and find the claim form (and other documents) saved to your device
- After closing the window, send additional documents marked with claim number to Tech1@riskprograms.com

Claim Data Entry Box 4: Finished

* Indicates a required field.

Event Information
Event Details
Person Involved
Finished

Contact Emails

	Additional Contact Email
	<input type="text"/> <input type="checkbox"/> Add Permanently?
	Add Email Address
	Remove Email Address <input type="checkbox"/> Remove permanently?

Note: Once a claim has been submitted, you will be able to attach files until the screen is closed.

Submit Claim



Schedule of Benefits - Student Accident Claims

Benefit	Standard	Economy	Deluxe
Medical expense limit	\$5,000	\$10,000	\$25,000
Inpatient room and board – usual and customary (U&C) – semiprivate room	\$300 first day \$150 each additional day	\$500 first day \$300 each additional day	\$1000 first day \$700 each additional day
Day surgery	up to \$500	up to \$1,000	up to \$1,500
Outpatient Physician visit expense	\$20	\$30	\$50
Outpatient Physiotherapy expense	\$20/day up to \$100	\$30/day up to \$250	\$50/day up to \$500
Outpatient Emergency Room expense	up to \$250	up to \$500	up to \$750
Outpatient X-Ray expense	up to \$100	up to \$250	up to \$500
Laboratory	U&C	U&C	U&C
Prescriptions	U&C	U&C	U&C
Outpatient durable medical equipment and supplies expense	up to \$100	up to \$200	up to \$300
Surgeon expense	U&C up to \$1,000	U&C up to \$2,000	U&C up to \$3,000
Assistant surgeon	30% of amount paid for surgery	30% of amount paid for surgery	30% of amount paid for surgery
Anesthetist or Anesthesiologist expense	30% of amount paid for surgery	30% of amount paid for surgery	30% of amount paid for surgery
Ambulance expense	up to \$100	up to \$250	up to \$500
Consultant	up to \$100	up to \$250	up to \$500
Outpatient Dental Accident Expense	\$150 per tooth \$600 max	\$250 per tooth	\$600 per tooth
Licensed Nurse Expense	\$70 per day	U&C	U&C
Motor Vehicle Accident Expense	\$500	\$1,000	\$2,000
Heat Exhaustion and Sunstroke	\$100	\$500	\$1,000

Student Accident Claims Recap

- VACORP is secondary to any other insurance
- Claims handled by knowledgeable professionals
- Follow-up info may be sent to tech1@riskprograms.com
 - additional documents, medical bills, EOBs
 - write school division name and claim number on all correspondence
 - » last 5 digits are unique identifier

NEW Catastrophic Student Accident Program

- Fills coverage gaps of VHSL Cat Program
- Limits available up to \$3,000,000
- Coverage is secondary to other insurance
- \$25,000 deductible
 - Out of Season Sports Practices and Scrimmages
 - Middle School Sports
 - Catastrophic Injuries
- Report claims as soon as possible

Catastrophic Student Accident Claim Form

Please select one of the following: Fatality Catastrophic Claim

PART 1: INCIDENT INFORMATION (TO BE COMPLETED BY THE SCHOOL)

School Division: _____

School Name: _____

School Address: _____

Student's Name: _____

Male Female Date of Injury/Fatality _____ Date of Birth: _____

Grade Level: _____

Body Part: _____

Description of Accident (Include an additional page if needed):

If Athletics, please indicate the sport: _____

At the time of injury, was the student involved in a School Division sponsored activity? Yes No

Under whose supervision? _____ Phone #: _____

Signature of Preparer: _____ Title: _____

Printed Name: _____ Date: _____ Phone #: _____

Catastrophic Student Accident Claim Form

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH *STUDENT* AND *PARENT* INFORMATION)

Student Information:

Student Address: _____

Parent Information:

Father's Name: _____ Phone #: _____

Father's Employer: _____

Employer's Address: _____

Mother's Name: _____ Phone #: _____

Mother's Employer: _____

Employer's Address: _____

Please list **ALL** insurance policies: Check if No Insurance

Name of Insurer: _____

Address: _____ Policy #: _____

Phone #: _____ Group Individual

Catastrophic Student Accident Claim Form

Treatment Information:

Physician/ Facility Name: _____

Address of Physician/ Facility: _____

Phone #: _____ Date Seen By Physician/ Facility: _____

Name and addresses of doctors attending the deceased following the accident:

Doctor: _____ Address: _____

Doctor: _____ Address: _____

Doctor: _____ Address: _____

Doctor: _____ Address: _____

Was this accident reported to the police department? Yes No If yes, indicate the name of the police department _____

Was an autopsy held? Yes No If so, who conducted the autopsy (Name and address): _____

Did the deceased have any chronic disease, physical defects or deformities? Yes No If yes, please describe: _____

Catastrophic Student Accident Claim Form

Instructions:

In case of an accident, notify the school immediately.

1. Complete this claim form and return it to the school within 180 days from the date of injury.
2. Please include information on any available health care insurance, including Medicaid.
3. In order to process this claim for payment, VACORP will need itemized bills and all Explanations of Benefits (EOB) showing what your insurance has paid. Statements without itemized information will not be accepted.
4. When you receive your EOB, send it to VACORP, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the contract.
5. Benefits are paid directly to the providers of service unless VACORP receives paid receipts.

Student Accident coverage is only available to cover students for accidental injury occurring while the contract is in force.

Benefits are provided on a **SECONDARY** excess basis for covered expenses **incurred and reported** within one year after the date of the accident.

Benefits are payable up to the applicable maximum for the covered expenses that are in excess of other valid and collectible insurance including: Medicaid, Medicare, FAMIS and private health insurance.

This claim form must be submitted to VACORP by the school division prior to any bills being reviewed or processed.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits; otherwise, VACORP's benefits may be reduced, where applicable, as stated in the contract provisions.

Required:

Please attach a copy of the death certificate to this form once the form has been completed and is ready to be returned to VACORP.

Catastrophic Student Accident Claim Form

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize all medical service sources and health care providers to disclose a complete copy of my health records, including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse to Virginia Association of Counties Group Self-Insurance Risk Pool, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as VACORP).

I authorize the use of the above information for VACORP to investigate, process and determine the amount payable, if any, for all claims made under any VACORP property and casualty contract that applies to the accident or occurrence on

_____. I understand as part of the claim handling process, VACORP may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professional for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be redisclosed and may not be

protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that VACORP has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s). This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and signed this document. I verify that the statement in Part 2 about other insurance is accurate and complete. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse VACORP to the extent VACORP made a payment for which it was not obligated under the contract. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Review – Student Accident Claims & CAT program

- Report claims within 90 days of injury
- Coverage is secondary to other insurance
- Contact your Central Office or Member Services for login
- Scan/Save claim form/other documents before login
- Claim inquiries call customer services line 888-822-6772
- Coverage available for Catastrophic injuries and death
 - Out of Season sports practices and scrimmages
 - Middle School sports
 - Tragic accidents, such as lab explosions
 - \$25,000 deductible

The **STRENGTH** you need.

The **PARTNERSHIP** you expect.



VACORP

Questions

Thank you for attending today's webinar!
For additional information, please contact
Member Services at 844-986-2705 or
info@riskprograms.com
For information about a claim please call our
Customer Services Line at 888-822-6772